7-1800-14010-2

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HUMAN SERVICES

In the Matter of the Immediate Suspension and Revocation of the License of Amy Stein to Provide Family Child Care	**FINDINGS OF FACT, CONCLUSIONS, AND RECOMMENDATION**

This matter was heard by Administrative Law Judge (ALJ) Richard C. Luis on February 22, 2001, in the Anoka County Courthouse, Room 250, Anoka, Minnesota. The record closed at the end of the hearing on February 22.

John R. Speakman, Assistant Anoka County Attorney, Anoka County Government Center, 2100 3rd Avenue, Anoka, MN 55308-2265, appeared on behalf of Anoka County Social Services ("the Local Agency", "Anoka County", or "the County") and the Minnesota Department of Human Services ("the Department"). Marc S. Berris, Esq., Segal, Roston & Berris P.L.L.P., 250 Second Avenue South, Suite 225, Minneapolis, MN 55401-2161 appeared on behalf of the Licensee, Amy Stein.

This Report is a recommendation, not a final decision. The Commissioner of Human Services will make the final decision after a review of the record which may adopt, reject or modify the Findings of Fact, Conclusions and Recommendations contained herein. Pursuant to Minn. Stat. §14.61, the final decision of the Commissioner of Human Services shall not be made until this report has been made available to the parties to the proceeding for at least ten days. An opportunity must be afforded to each party adversely affected by the Report to file exceptions and present argument to the Commissioner of Human Services. Parties should contact Commissioner Michael O'Keefe, Minnesota Department of Human Services, Human Services Building, 444 Lafayette Road, St. Paul, Minnesota 55155-3815, telephone (651) 296-2701, to ascertain the procedure for filing exceptions or presenting argument.

STATEMENT OF ISSUES

The issues in this case are whether Licensee failed to ensure proper supervision of day care children as required by Minn. Rules 9502.0315, subp. 29a, failed to correct a known hazardous condition as required by 9502.0435, subp. 6, whether it was appropriate to suspend her family child care license immediately because of an incident on June 2, 2000 involving the failures alleged, and whether her license should be revoked for the failures alleged.

Based upon the record herein, the Administrative Law Judge makes the following:

FINDINGS OF FACT

1. The Licensee was born December 1, 1969, and is a high school graduate. The Licensee began providing unlicensed day care in 1996. The Licensee resides with her husband, Gregory, and their three children, ages 8, 5, and 4.

2. The Licensee applied for a family child care license in March 1999. As part of the licensing process, the Licensee was visited by Carol Marchand, a day care licensing inspector for Anoka County. The Licensee completed a checklist of information about the program that she would be offering children in care.[1] The Licensee indicated that the day care children would be using an outdoor play structure. The Licensee would supervise outdoor play by staying in the back yard (where the structure was located). Ms. Marchand noted "Good" by both of these descriptions.[2] The Licensee's family day care application was approved after the visit.[3] The Licensee's family child care license was renewed in May 2000.[4] Licensee was authorized to have up to ten children in her care.[5]

3. The day care premises are a two-level home and fenced back yard.[6] The upper level of the home includes the kitchen. The kitchen opens directly onto a deck in the back yard.[7] The view from the kitchen includes the outdoor play structure and the area around that structure. The outdoor play structure is approximately thirty-five feet from the deck.

4. The outdoor play structure consists of an open platform, approximately three feet above the ground, with a slide at one end and a sliding pole at the other.[8] Sides rise another three feet from the platform and timbers connect the two sides at each end. Each timber reaches out beyond one side for approximately 2 ½ feet. Attached to one timber is a rope ladder with wooden rungs. Attached to the other timber is a knotted climbing rope.

5. On June 2, 2000, the Licensee was providing care to seven children. Her neighbor, Cindy Janisch, was over with three children at about 10:00 a.m. Janisch is also a licensed day care provider. The two providers were planning to take the ten children for a walk. Since one of the children needed to use the bathroom shortly into the walk, the trip was cut short. When the Licensee, Janisch, and the children returned to Ms. Stein's home, the preschool children played in the back yard.

6. While playing in the back yard, the Licensee's four-year-old child wrapped the climbing rope on the play structure around her chest and tried to swing on the rope in that fashion. Janisch observed the child using the climbing rope that way and told the Licensee. The Licensee did not see her daughter using the climbing rope in that way, but told her daughter to stop the behavior. In playing with the climbing rope, the child had not stood on top of anything to wrap the rope around her chest. At no time did that child hurt herself in playing with the climbing rope. Nothing about the behavior suggested to the Licensee or Janisch that there was any immediate risk of harm posed by the climbing rope.

7. R.C., age 3, was dropped off at the Licensee's day care at approximately 11:00 a.m. All of the children had lunch at the Licensee's day care. After lunch, all but two of the day care children began playing in the back yard. The oldest child in the back yard was five years old. The two day care children not playing in the back yard were an infant, five months old, and a toddler, one year old. Both of those two children were in the kitchen, but they would be going outside as soon as they were ready.

8. The Licensee and Janisch supervised the children from the deck, which is situated just off of the kitchen and fully overlooks the back yard. Both caregivers were in and out of the house to attend to various needs during this time. Janisch came in from the deck and occupied herself with readying the infant to go outside. She could see the play structure from where she was standing. Janisch could also hear the children playing in the back yard. The kitchen window and door were both open. The Licensee then came in from the deck and told Janisch that she (the Licensee) was going to the bathroom. Janisch understood the Licensee to mean that Janisch would be "keeping an eye on the children."[9] Janisch was never out of the hearing of the day care children in the back yard during this time.

9. Janisch began trying to remove the infant from a high chair, so that they could go outside. She focused her attention on the kitchen, because the infant was in an unfamiliar high chair and Janisch did not know how to work the mechanism. She had spent 60 to 90 seconds attending to the infant when the Licensee's five-year-old son came in the kitchen and said that R.C. was choking. Janisch looked out the window and saw R.C. hanging by the neck from the climbing rope. Janisch uttered "Oh, my God" and rushed into the back yard.

10. The Licensee heard Janisch and immediately left the bathroom to come out into the back yard. Along the way, the Licensee grabbed a cordless telephone. When Janisch reached R.C., the girl was still hanging with the rope around her neck and was choking. Janisch lifted R.C. and removed the rope from around her neck. Near the climbing rope was a short, lightweight side table.[10] Janisch was carrying R.C. back toward the deck when Licensee got to the yard. R.C. was gasping and she was not fully conscious. The Licensee immediately called 911 to report the emergency and request assistance.

11. Officer Shayle Schulz of the Anoka Police Department received the 911 dispatch regarding the child's condition and responded to the call. Investigators Patterson and Peterson overheard the call for Officer Schulz to respond to the day care premises. The investigators arrived and administered oxygen to R.C., who was unconscious. When Officer Schulz arrived, Investigators Patterson and Peterson were providing emergency care to R.C. and they directed Schulz to interview the adults present.

12. The Licensee was continuing to provide care for the day care children during and after the incident. At the same time, the Licensee was making numerous telephone calls to locate R.C.'s mother to inform her of the incident. Officer Schulz asked questions of the Licensee and Janisch while these things were going on. Officer

Schulz asked the Licensee and Janisch whether such an incident had happened before. Janisch speculated that R.C. must have been standing on the side table when playing with the climbing rope. Officer Schulz understood the Licensee to say that at some time in the past her daughter had done "the exact same thing." The Licensee was referring to the morning incident with her four-year-old daughter. The Licensee did not describe the morning incident (since the Licensee had not seen that incident). The Licensee had not seen the incident involving R.C. Officer Schulz asked no questions to clarify what Licensee had meant. No one asked any questions of any of the day care children. Officer Schulz spent no more than twenty minutes at the day care. At the end of her shift, Officer Schulz wrote a report of the incident and included the following statement:

> Miss Stein then advised that in the past that her daughter has done the exact same thing, pulled over the white table and wrapped the rope around her neck – but they were able to catch her prior to hanging.[11]

13. Based on the perception that "someone had done it [misused the climbing rope] before," Investigator Peterson indicated to Officer Schulz that the incident should be reported as a home accident report rather than a medical call.[12]

14. R.C. was taken by ambulance to the hospital. The Licensee drove to the hospital, leaving the day care children in the care of Janisch and an adult friend. R.C. suffered from burst capillaries in the roof of her mouth and aggravation of R.C.'s already swollen tonsils. The Licensee called the County from the hospital to report the injury.[13]

15. Due to the seriousness of the potential harm, Anoka County Child Protection (Child Protection) was advised of the June 2, 2000 incident. Child Protection relied upon Officer Schulz's report to conclude that there had been a prior incident where a child had attempted to wrap the climbing rope around her neck. Child Protection interviewed the Licensee on June 19, 2000. In that interview, the Child Protection worker asked the Licensee about the earlier misuse of the climbing rope. The Child Protection worker's report on those portions of the interview states:

> This worker asked Amy [the Licensee] about the police report, particularly the statement that [her daughter] had done the exact same thing that morning. Amy stated that she was not sure what she and Cindy [Janisch] told the police because they were in a panic. Amy said that [her daughter] did not pull a table over and she did not have the rope around her neck, but rather had the rope around her body.
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> This worker asked Amy if there had been any other concerning incident with the rope and she denied that there had been. Amy said that she did not think what her daughter did that morning looked dangerous. Amy told this worker that she has had that rope in her back yard for three years and

she has never had any problems with it before. Amy stated that she removed the rope after returning from the hospital.

* * *

This worker again asked Amy about the police report that indicated that [her daughter] had done the same thing with the rope previously. Amy stated that Cindy told the police that [Licensee's daughter] had done the same thing that morning and she had just agreed with her. Amy stated that she did not know what she was saying. Amy told this worker that no other child has done this kind of thing before at her home.

* * *

This worker asked Cindy about the incident with [Licensee's daughter] and the rope and she said that [Licensee's daughter] had the rope around her waist. Cindy also verified that Amy yelled at [her daughter] for this and [R.C.] was not present during this incident.[14]

16. Based on its investigation, Child Protection substantiated a finding of neglect by the Licensee.[15] Ms. Stein requested reconsideration of the neglect finding and the finding was withdrawn.[16]

17. The Department issued an Order of Immediate Suspension of Licensee from providing family day care on June 9, 2000.[17] That Order was appealed on June 12, 2000.[18] The Department issued an Order of Revocation of Licensee's family day care license on December 12, 2000.[19] The Licensee appealed the Order of Revocation on December 15, 2000.[20]

18. The Department issued a Notice of and Order for Hearing in this matter for each of the Orders issued.[21] Both of the Notices were served on the Licensee. The parties have agreed to combine the two appeals in this proceeding.

19. No adverse action was ever proposed or taken against the day care license of Janisch as a result of the June 2, 2000 incident.

Based upon the foregoing facts the Administrative Law Judge makes the following:

CONCLUSIONS

1. The Administrative Law Judge and the Commissioner of Human Services have jurisdiction over this matter pursuant to Minn. Stat. §§14.50 and 245A.08.

2. The Notice of Hearing is proper in all respects and the Local Agency and the Department have complied with all substantive and procedural requirements of law and rule.

3. Minn. Rule 9502.0315, subp. 29a, defines "supervision" as:

"Supervision" means a caregiver being within sight or hearing of an infant, toddler, or preschooler at all times so that the caregiver is capable of intervening to protect the health and safety of the child. For the school age child, it means a caregiver being available for assistance and care so that the child's health and safety is protected.

4. The Licensee met the requirement that a caregiver supervise the children in her day care within the meaning of Minn. Rule 9502.0315, subp. 29a. At all times a caregiver was within “sight or hearing” of all the children in the day care and capable of intervening to protect the health and safety of the children.

5. The Licensee met the hazardous activity standard of Minn. Rule 9502.0435, subp. 6. The climbing rope and side table are not hazardous materials by their nature. Their proximity to each other in the Licensee’s yard did not constitute an “other potential hazard” within the meaning of Minn. Rule 9502.0435, subp. 6. The use of the two in combination with each other to result in a hanging incident was not reasonably foreseeable.

6. Since the Licensee has complied with the rules governing day care licensure, no sanctions are appropriate under Minn. Stat. § 245A.07.

Based upon the foregoing Conclusions, the Administrative Law Judge makes the following:

RECOMMENDATION

IT IS RECOMMENDED that the immediate suspension of the Family Day Care License of Amy Stein be lifted and the proposed revocation of her License be dismissed.

Dated this 16th day of March, 2001.

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RICHARD C. LUIS
Administrative Law Judge

NOTICE

Pursuant to Minn. Stat. §14.62, subd. 1, the Agency is required to serve a copy of its final decision upon each party and the Administrative Law Judge by first class mail.

Reported: Tape recorded, 4 tapes.

MEMORANDUM

Supervision

The County maintains that Licensee violated the supervision standards required of children in day care by paying insufficient attention to day care children outside. The only incident cited is the incident with R.C. and the climbing rope.

Supervision for infants, toddlers, and preschoolers requires a caregiver to be within "sight **or** hearing."[22] The County's day care licensor (Marchand) indicated that she perceived the proper supervisory standard to be that the day care children were being watched in the back yard. The standard suggested by the County is more stringent than what is actually required in the rules.

If the day care children are not in sight of the caregiver, subpart 29a requires that the children be within the hearing of the caregiver. As the County's day care licensor testified, "**Apparently**, it wasn't heard, … **if** the other children were yelling, it wasn't heard."[23] The Department relies on this perception to conclude that the children in the back yard were not being supervised. The facts in the record demonstrate otherwise.

Janisch was attending to an infant in the kitchen, with the windows and door open to the back yard. In attending to that child, she had her back to the window and the children in the back yard. No witness testified that the children were calling for help and not being heard. Janisch testified credibly that her attention was away from the back yard for 90 seconds or less before a child came in to the kitchen seeking help for R.C.

Even R.C.'s mother noted that the incident in this matter "may be a freak accident."[24] The mere fact that a child could put herself in a momentary position of hazard does not demonstrate a violation of the supervision requirement. The fact that both caregivers on the day care premises were in a position to intervene before more serious, lasting harm came to the child demonstrates the propriety of the Department's definition of supervision. The standard is that caregivers must be "within sight or hearing … at all times so that the caregiver is capable of intervening to protect the health and safety of the child."[25] The caregiver is not required to keep children in sight at all times to prevent children from encountering any risk of harm.

Hazardous Activity Materials

The County alleges that the Licensee violated Minn. Rule 9502.0435, subp. 6, by allowing a day care child to play with a climbing rope and a table. This standard is contained in the "Sanitation and Health" portion of the family child care rules. The other standards set out in that part govern cleanliness, toxic substances, rubbish, firearms, use of restraints in transportation, and appropriate responses to emergencies. Subpart 6 states in full:

> Subp. 6. **Hazardous activity materials.** Knives, matches, plastic bags, and other potential hazards must be kept out of the reach of infants,

toddlers, and preschoolers. The use of potentially hazardous materials and tools must be supervised.

A climbing rope does not fall within the same category as "knives, matches, plastic bags, and other potential hazards." By its nature, a climbing rope must be within reach of a child to be used. The other item identified by the County as "hazardous" is a small side table. The table is, if anything, less hazardous than the climbing rope. It likely was in the yard as an adjunct to the lawn chairs also present there. And, as concluded above, their proximity to each other in the yard does not suggest that a child would use the two together to abet a hanging incident.

The County's day care licensor (Marchand) examined the outdoor structure as part of the licensing process. The only problem with that structure that she identified was roughness of some of the bolts holding it together.[26] If the hazard posed to children by the climbing rope was foreseeable, the licensor seemingly would have mentioned it at the time of inspection. The County's day care licensor (Marchand) indicated that other day care homes that she has inspected have equipment with climbing ropes.[27] She noted that "I would not have thought of that particular use, but kids are innovative."[28] The ALJ concludes that the Licensee, in this instance, likewise was not required to "have thought of that particular use."

The Department asserts that the Licensee had warning that the climbing rope was dangerous because Licensee's daughter had "earlier on the same day, … pulled the table over to the climbing rope and wrapped the rope around themselves (*sic*), but had been rescued before hanging."[29] With such prior warning, the Department maintains that the Licensee's failure to remove the climbing rope or the table constitutes a violation of Minn. Rule 9502.0435, subp. 6.

The Administrative Law Judge has carefully assessed the statements of the witnesses and their credibility in arriving at the Findings of Fact in this matter. The ALJ finds that both caregivers' descriptions of the earlier incident are credible and accurate. The earlier incident had a child wrap the climbing rope around her waist. The table was not used in that incident. The child did not need to be "rescued." The earlier incident provided no warning that a child would later wrap the climbing rope around her neck.

Without prior warning, the Licensee could not possibly foresee that a child could use the climbing rope in a manner that was so hazardous.[30] No prior warning of a hazard was available to the Licensee, from the earlier incident or any other use of the climbing rope over the three years that the climbing rope has been present in her back yard. When Ms. Stein became aware of the potential for harm to children, she immediately removed the climbing rope. The County has not demonstrated any violation of Minn. Rule 9502.0435, subp. 6. The Licensee has demonstrated that she was in full compliance with that rule.

Caregiver Responsibility

The Department's licensing scheme authorizes a single caregiver to provide care to up to ten children. No helper or second caregiver is required to be present for that number of children. In this matter, the Licensee informed an adult caregiver that the Licensee would be using the bathroom and left the second caregiver in charge. The County has not taken account of this fact in any of its arguments. Under the Department's licensing scheme, there is an assumption that for short periods no adult will be within sight of the day care children. In this matter, the responsibility for supervision had been passed to another licensed caregiver for just such a short period. Had the supervision standard been violated in this matter (and it was not) the responsible party at that particular moment was not the Licensee. Sanctions against the Licensee under such circumstances are inappropriate.

Neglect

The County noted that an initial finding of neglect was made by Child Protection. That finding was reversed on reconsideration.[31] Under Minn. Stat. § 245A.04, subd. 3b(e), the results of neglect findings cannot be challenged in contested case proceedings regarding licensure. The finding of no neglect made on August 16, 2000, by the County is final and cannot be re-litigated here.

Post-Accident Events

Evidence was introduced in this matter concerning events that occurred after the accident and the report of the accident to 911 and R.C.'s mother. None of these events have been shown to be material to the issues of rule compliance appropriate to this matter.

Conclusion

The record in this matter demonstrates clearly that the Licensee operated her day care in compliance with the applicable rules regarding supervision and access to hazardous materials. The approach taken by the County implies a new standard, one that finds a rule violation based solely on the fact of an injury to a day care child. That standard is nowhere in the rules and is contradicted by prior licensing actions.[32] Sanctions against the Licensee are inappropriate since she has not violated any rule governing the conduct of her day care. Therefore, the Administrative Law Judge recommends that the immediate suspension be lifted and the proposed revocation be dismissed.

R.C.L.

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[1] Ex. 9.
[2] *Id*.
[3] Ex. 12.
[4] Ex. 17.

[5] *Id*.
[6] Ex. 11.
[7] Ex. 22a.
[8] Ex. 22b.
[9] Janisch Testimony, Tape 2.
[10] Ex. 22b.
[11] Ex. 21, at 3.
[12] Peterson Testimony, Tape 2.
[13] Ex. 19.
[14] Ex. 24 (with not public identifying information redacted).
[15] Ex. 24.
[16] Ex. 25.
[17] Ex. 1.
[18] Ex. 2.
[19] Ex. 4.
[20] Exs. 1 and 2.
[21] Exs. 3 and 6.
[22] Minn. Rule 9502.0315, subp. 29a (emphasis added).
[23] Marchand Testimony, Tape 1 (emphasis added).
[24] Ex. 24, at 4.
[25] Minn. Rule 9502.0315, subp. 29a.
[26] Marchand Testimony, Tape 1.
[27] Marchand Testimony, Tape 2.
[28] *Id*.
[29] Ex. 4, at 2.
[30] Where a truly foreseeable hazard arises from a common piece of playground equipment, specific legislation, rulemaking, or a guideline is applied to govern the use of that equipment. See Ex. 26, at iv-vi (applying special standards to the use of wading pools in daycare). Requiring that the Licensee foresee the potential for misuse of the climbing rope as was done in this instance would be contrary to the intent of the hazardous materials rule.

The "special standards" for use of wading pools in daycare settings include a required parental consent form and the advisory that "Submersion incidents … happen quickly, even in the time it takes to answer the phone." Ex. 26, at vi. The implication of that consent form and advisory is that caregivers are not expected to keep the daycare children in sight at all times, even when using a wading pool – a known hazard that can cause a child's death. The Department seems to recognize that eyes-on supervision of children in care 100 percent of the time is not feasible, so it is not required.
[31] Ex. 25.
[32] See ***In Re Pogalz***, OAH Docket No. 1-1800-11618-2 (Recommendation issued July 6, 2000).